

Office of Health Facilities

Application for Home Care Agency Facilities

Reference Guide for New Applicants

Let's begin!

Log In to the platform

1 Enter your username and password.

2 Click the Log In button.

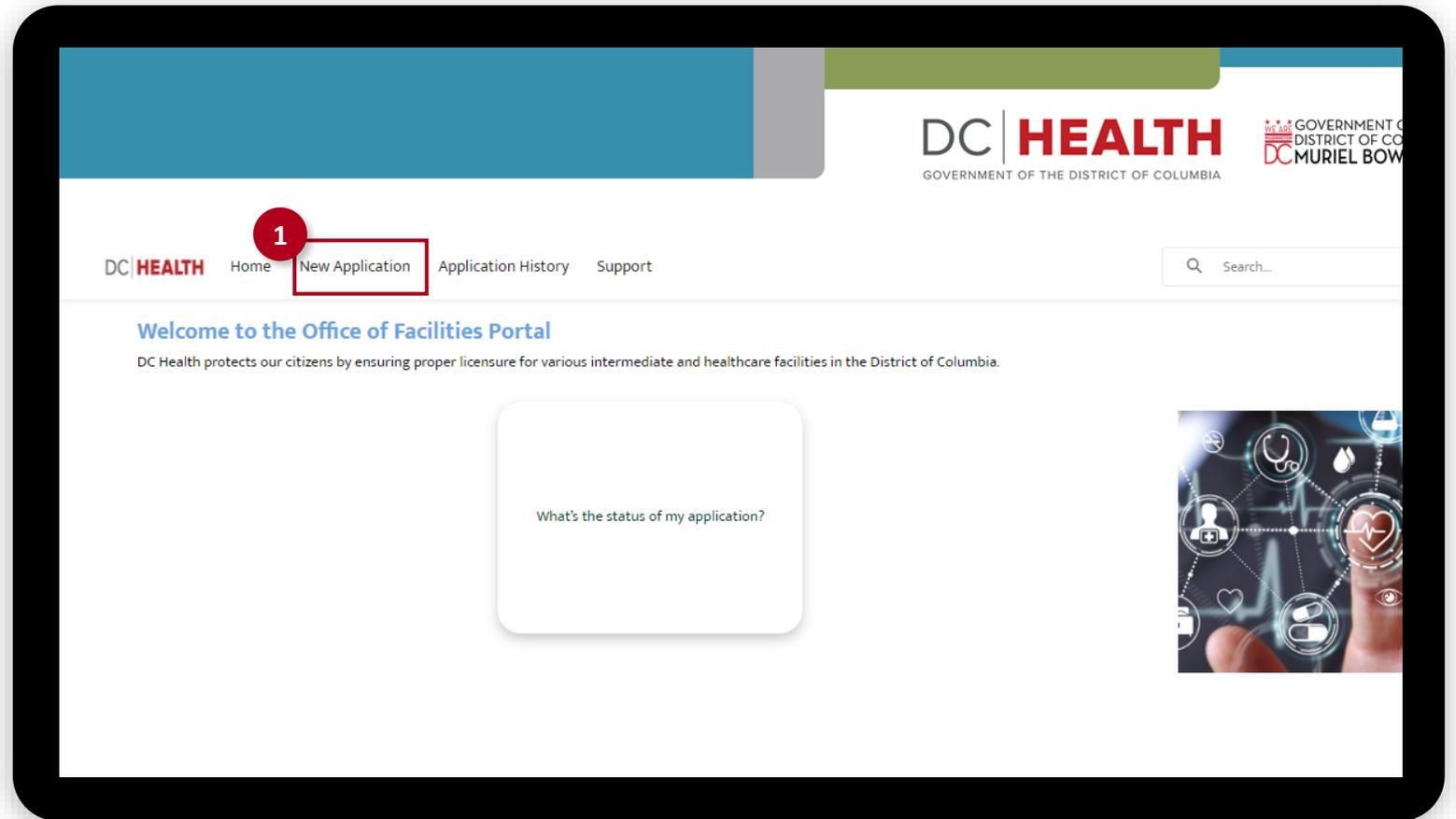


TIP: If you don't have an account click the **Create New Account** link.

The screenshot shows the DC Health login page. At the top right, there is a header with the DC Health logo and the text "GOVERNMENT OF THE DISTRICT OF COLUMBIA" and "MURIEL BOWSER, MAYOR". Below the header, the page is titled "DC HEALTH" and "Welcome to the Office of Health Facilities Portal". The main content area contains a login form with two input fields: "TestUser17" for the username and "....." for the password. A blue "Log in" button is positioned below the password field. To the right of the login form, there is a section titled "Login or Create an Account to:" with a list of options: "Apply for a new medical facility license", "Renew an existing medical facility license", "Check the status of past applications", and "Seek support related to interactions with this office". Below this, there is a section titled "About DC Health" with a paragraph of text. At the bottom left of the login form, there are links for "Forgot your password?" and "Forgot username?". At the bottom right, there is a link for "Create New Account".

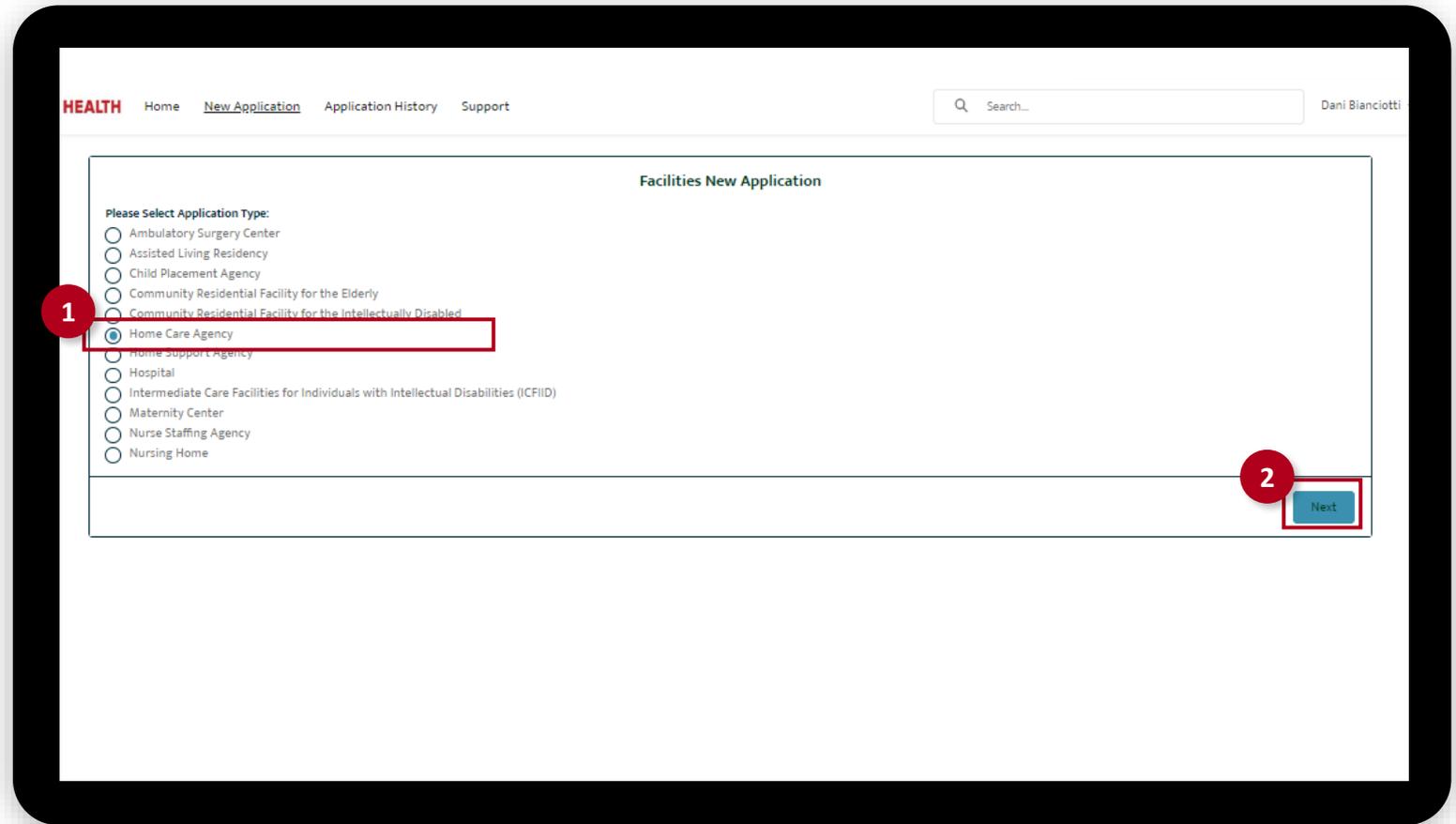
Navigate to the New Application screen

- 1 Once you Log in to the Office of Facilities Portal, click the **New Application** tab.



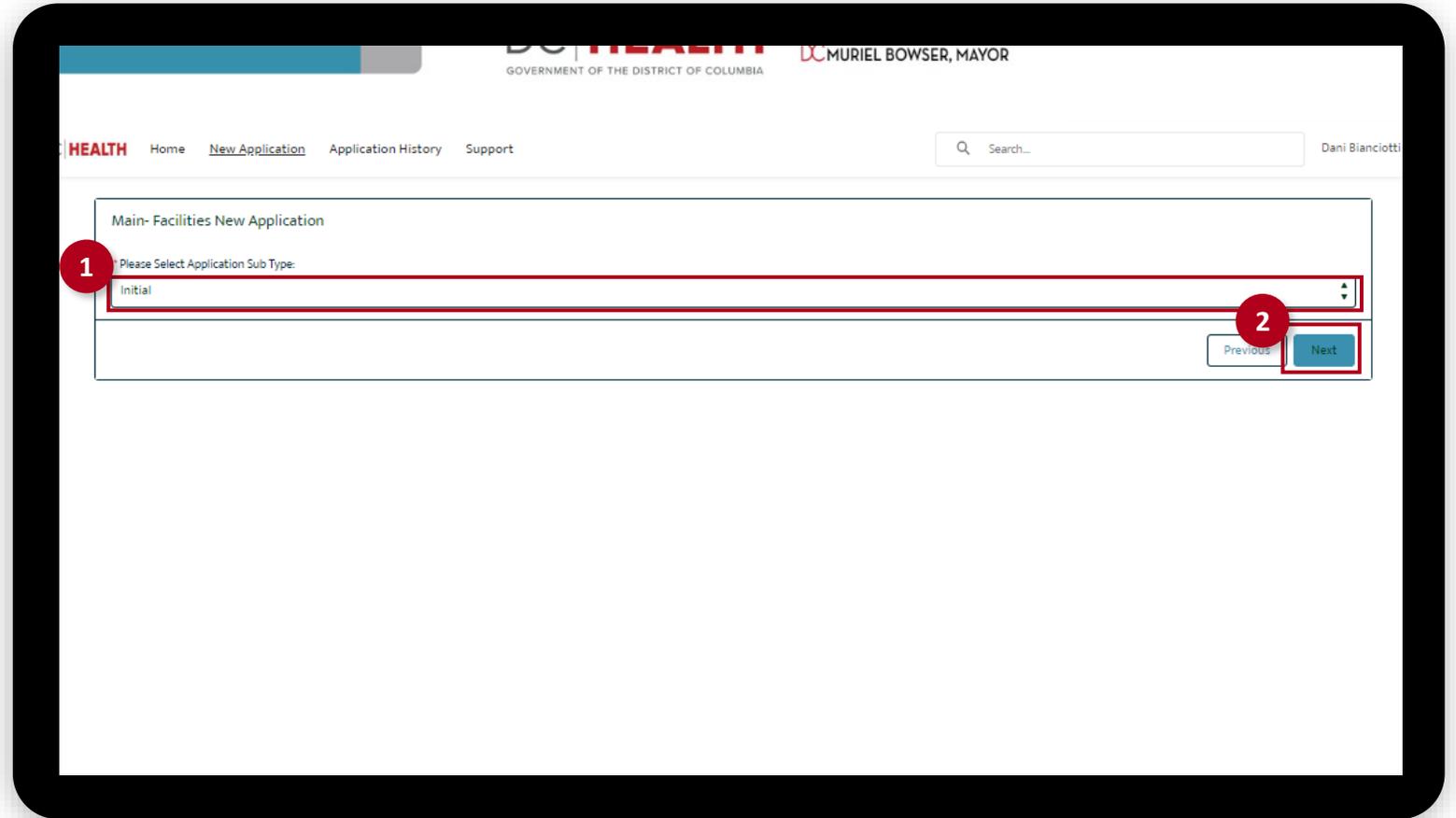
Select the Facilities New Application

- 1 Select the Home Care Agency option from the list.
- 2 Click the Next button.



Select the Application Sub Type

- 1 Select the **Initial** option from the drop-down list.
- 2 Click the **Next** button.



Fill out the Agency Information

- 1 Fill out all the required fields.
- 2 Click the **Save & Next** button.

Agency Information

*Facility Name: Elisha Huel
City: Lake Salgeview
*Telephone Number: 399-386-4685
Fax Number: 919-149-7778
 Is Mailing address different?
Number of Patients: 100
*Contact Person First Name: Rafaela
Contact Person Middle Name: Nadia Ziemann
*Contact Person Last Name: Kuhn
*Telephone Number: 942-180-3562
Email Address: 382-902-0439

Street Address: 355 Ezequiel Branch
State: MD
*Zip Code: 13447
Email: your.email=fakedata54105@gmail.com

Street Address: 54518 Champlin Stream
City: South King
State: MA
*Zip Code: 53413

2 Save & Next



TIP: If the mailing address is different from the information filled out in the Facility information fields, select the **Is Mailing Address different?** check box.

Select the Services Provided

- 1 Select all the Services Provided by the Home Care Agency.
- 2 Click the Save & Next button.

DC|HEALTH Home [New Application](#) Application History Support

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Services Provided

1

* Please Select All That Apply:

- Occupational Therapy
- Personal Care Aide Services
- Home Health Aide Services
- Intravenous Therapy
- Medical Social Services
- Physical Therapy
- Skilled Nursing
- Speech Language Pathology
- Adult-Only
- Pediatric-Only
- Adult & Pediatric
- Other (Please specify)

2 Save & Next

The fields marked with * are mandatory and must be filled out to continue.

Fill out the Applicant/Owner Information

- 1** Select if the Applicant is an:
- Individual
 - General Partnership
 - Limited Partnership
 - Corporation
 - Other
- And fill out all the required fields.

- 2** Click the **Save & Next** button.

1

Applicant/Owner Information

* Applicant is an:

- Individual
- General Partnership
- Limited Partnership
- Corporation
- Other (Please specify)

If the applicant is a limited partnership corporation, list the names, document number and federal identification number registered with the District of Columbia, Division of Corporation within the Department of Consumer and Regulatory Affairs.

Name:

Street Address: City:

State: Zip Code:

Document Number: Federal Employer Identification Number:

If a limited partnership/corporation, please attach a current copy of your Certificate of Good Standing issued by the Division of Corporations within the Department of Consumer and Regulatory Affairs.

Corporation Status:

The property and buildings are:

Is the agency to be managed by someone other than the applicant?:

2 Save & Next

The fields marked with * are mandatory and must be filled out to continue.

Fill out the Owner Information

If the applicant(s)/owner(s) is an/are individual(s), complete this screen.

- 1 Fill out all the required fields.
- 2 Click the **Save & Next** button.

The fields marked with * are mandatory and must be filled out to continue.



TIP: If needed, select the **Add more Individual Owners** check box.

Fill out the Director's Information

- 1 Fill out all the required fields
- 2 Click the **Save & Next** button.

The screenshot shows a web form titled "Director's Information" on the DC Health portal. The form includes the following fields and questions:

- * First Name: Text input with "Ayden" entered.
- MI: Text input with "vai" entered.
- * Last Name: Text input with "Zieme" entered.
- Is the Director a licensed physician?: Dropdown menu with "Yes" selected.
- Is the Director a licensed registered nurse?: Dropdown menu with "No" selected.
- What date did the above person begin employment with the facility as the director?: Date picker with "Aug 30, 2022" selected.
- Does the Director have training and experience in health services administration, including at least one (1) year of supervisory or administrative experience in home health care or related health programs?: Dropdown menu with "Yes" selected.
- Will the director be serving as director of more than this HCA?: Dropdown menu with "No" selected.
- If so, provide the name of the other facilities: Two pairs of text inputs for Facility Name and License Number.

Annotations: A red circle with the number "1" is placed over the top three text input fields. A red circle with the number "2" is placed over the "Save & Next" button at the bottom right of the form.

 **TIP:** If needed, use the **Upload Files** button to attach needed documentation.

*The fields marked with * are mandatory and must be filled out to continue.*

Fill out Insurance Coverage information

- 1 Select **Yes/No** in the required fields. Upload documentation by clicking the **Upload Files** button.
- 2 Click the **Next** button.

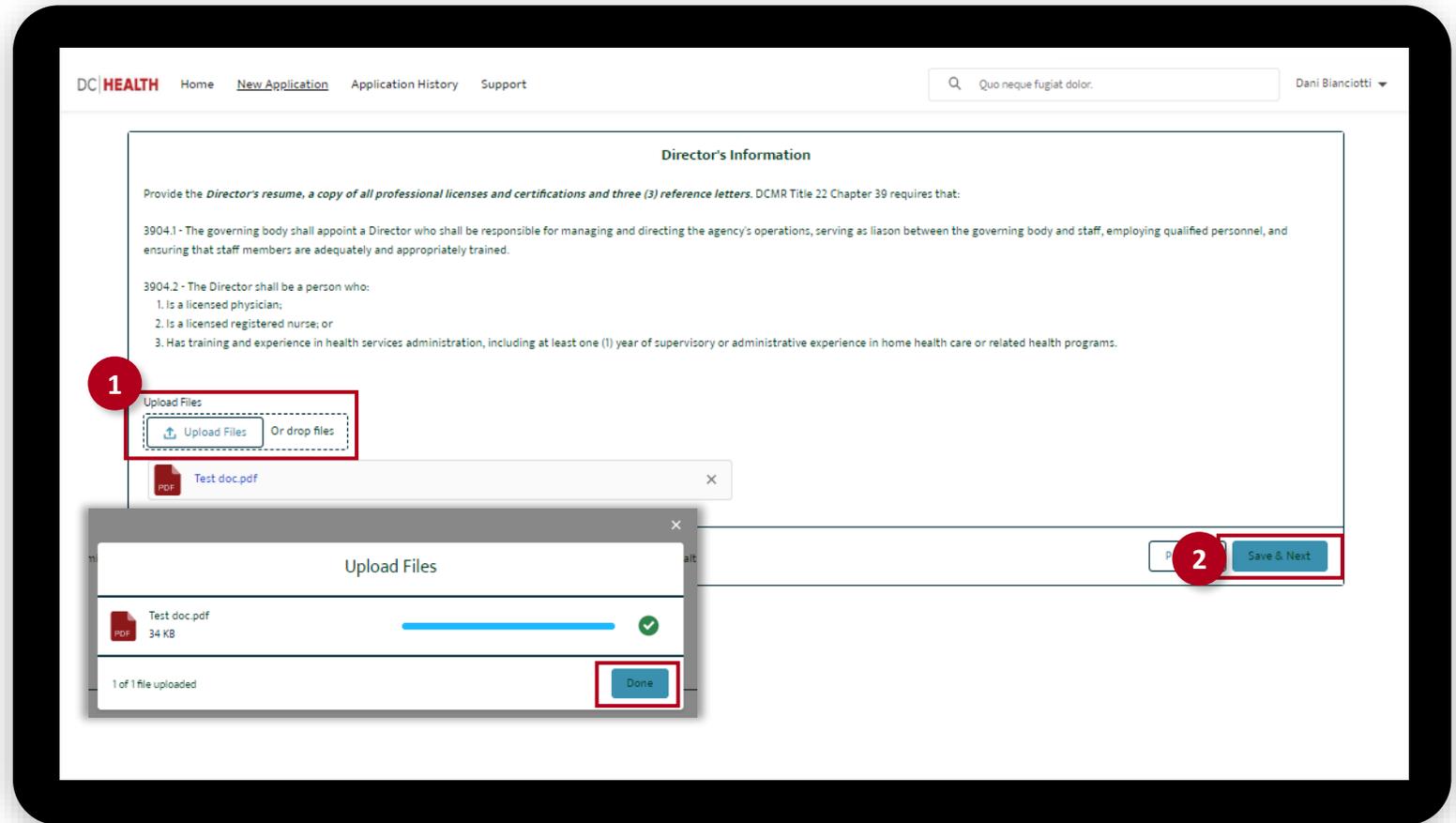
The screenshot shows the 'Insurance Coverage' section of the DC HEALTH application. At the top, there is a navigation bar with 'DC HEALTH', 'Home', 'New Application', 'Application History', and 'Support'. A search bar contains 'Provident laborum qui.' and a user name 'Dani Bian'. The main form area is titled 'Insurance Coverage'. A red circle with the number '1' highlights a dropdown menu with the question 'Does the facility have Liability insurance?' and the option 'Yes' selected. Below this is a section for 'Please provide documentation of insurance.' with two buttons: 'Upload Files' and 'Or drop files'. At the bottom right of the form, a red circle with the number '2' highlights a 'Next' button.

The fields marked with * are mandatory and must be filled out to continue.

Fill out the Director's Information

1 Upload the Director's resume, a copy of all professional licenses and certifications and three reference letters by clicking the **Upload Files** button. Once the document is selected and the checkmark appears, click the **Done** button in the pop-up.

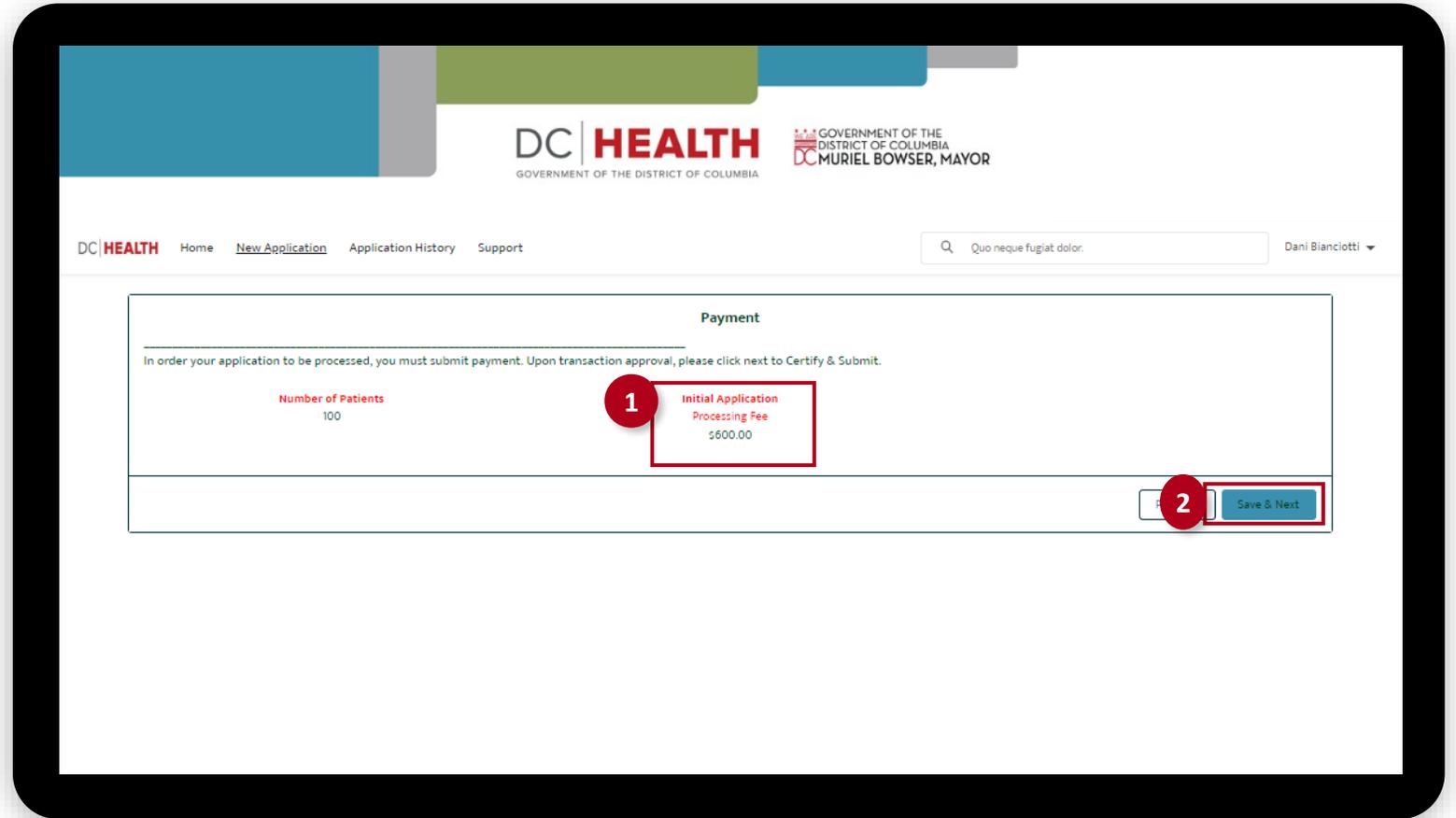
2 Click the **Save & Next** button.



The fields marked with * are mandatory and must be filled out to continue.

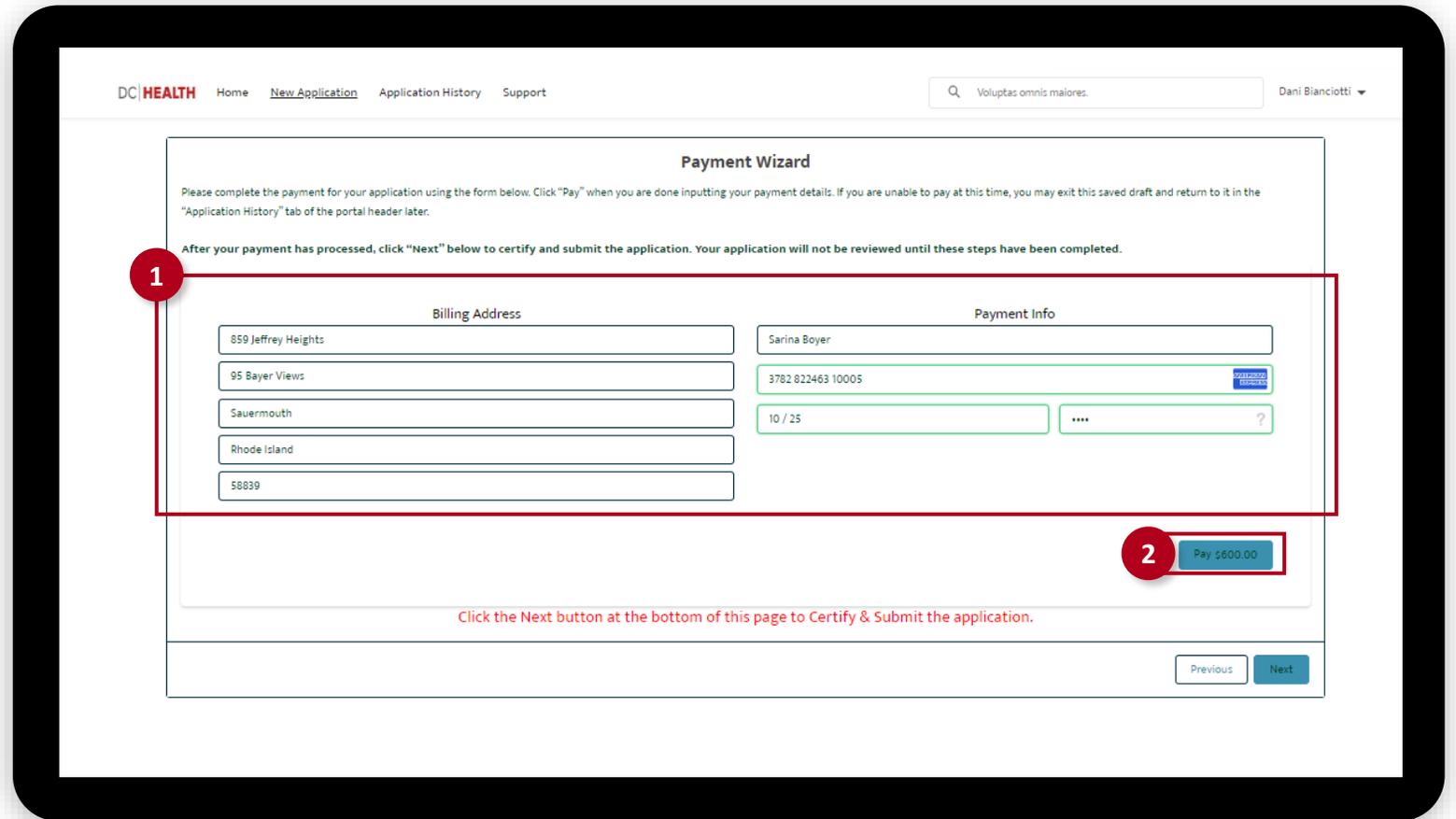
Payment Selection

- 1 Check if Initial Application Processing Fee is correct.
- 2 Click the Save & Next button.



Payment Wizard

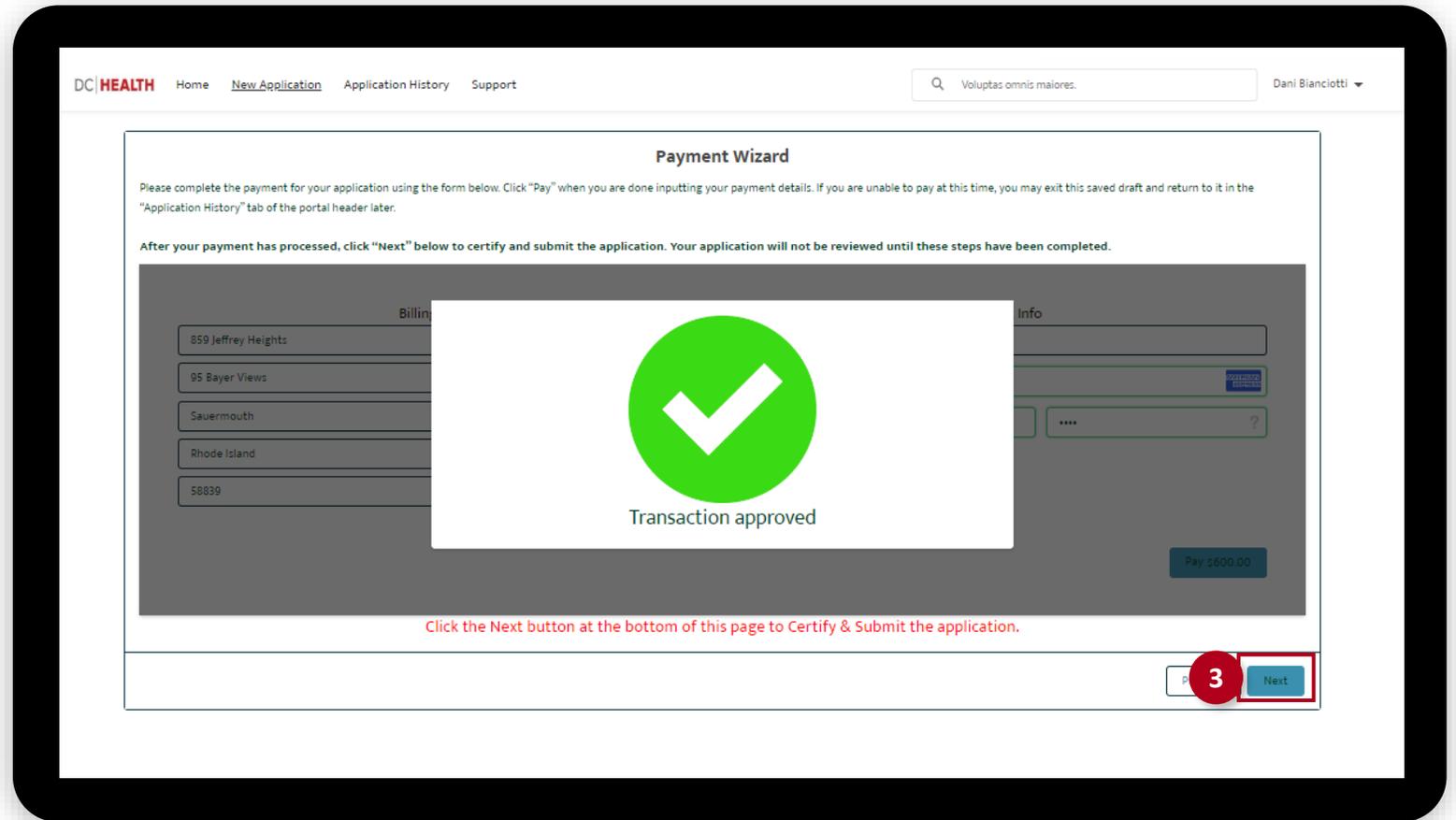
- 1 Fill out the **Billing Address** and **Payment Info** fields.
- 2 Click the **Pay** button.



Payment Wizard



- 3 Once the Transaction is approved, click the Next button.



Certify and Submit

1 Fill out the Name field.

2 Click the Submit button.

DC HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, N

HEALTH Home [New Application](#) Application History Support

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Certify and Submit

By clicking the submit button below, you are acknowledging that you are providing information for an official record and that the information you are supplying is true. By submitting this information, you understand that knowingly and willfully making a false statement on an official record may result in action against your license, registration, or certification and criminal penalties*. This information will be held confidential by the Department of Health.

*(a) A person commits the offense of making false statements if that person willfully makes a false statement that is in fact material, in writing, directly or indirectly, to any instrumentality of the District of Columbia government, under circumstances in which the statement could reasonably be expected to be relied upon as true; provided, that the writing indicates that the making of a false statement is punishable by criminal penalties or if that person makes an affirmation by signing an entity filing or other document under Title 29 of the District of Columbia Official Code, knowing that the facts stated in the filing are not true in any material respect or if that person makes an affirmation by signing a declaration under § 1-1061.13, knowing that the facts stated in the filing are not true in any material respect; (b) Any person convicted of making false statements shall be fined not more than the amount set forth in § 22-3571.01 or imprisoned for not more than 180 days, or both. A violation of this section shall be prosecuted by the Attorney General for the District of Columbia or one of the Attorney General's assistants.

By electronically entering my name on this form, I attest that all statements are true and accurate.

* Name
Concepcion Doyle

Date
January 24, 2023

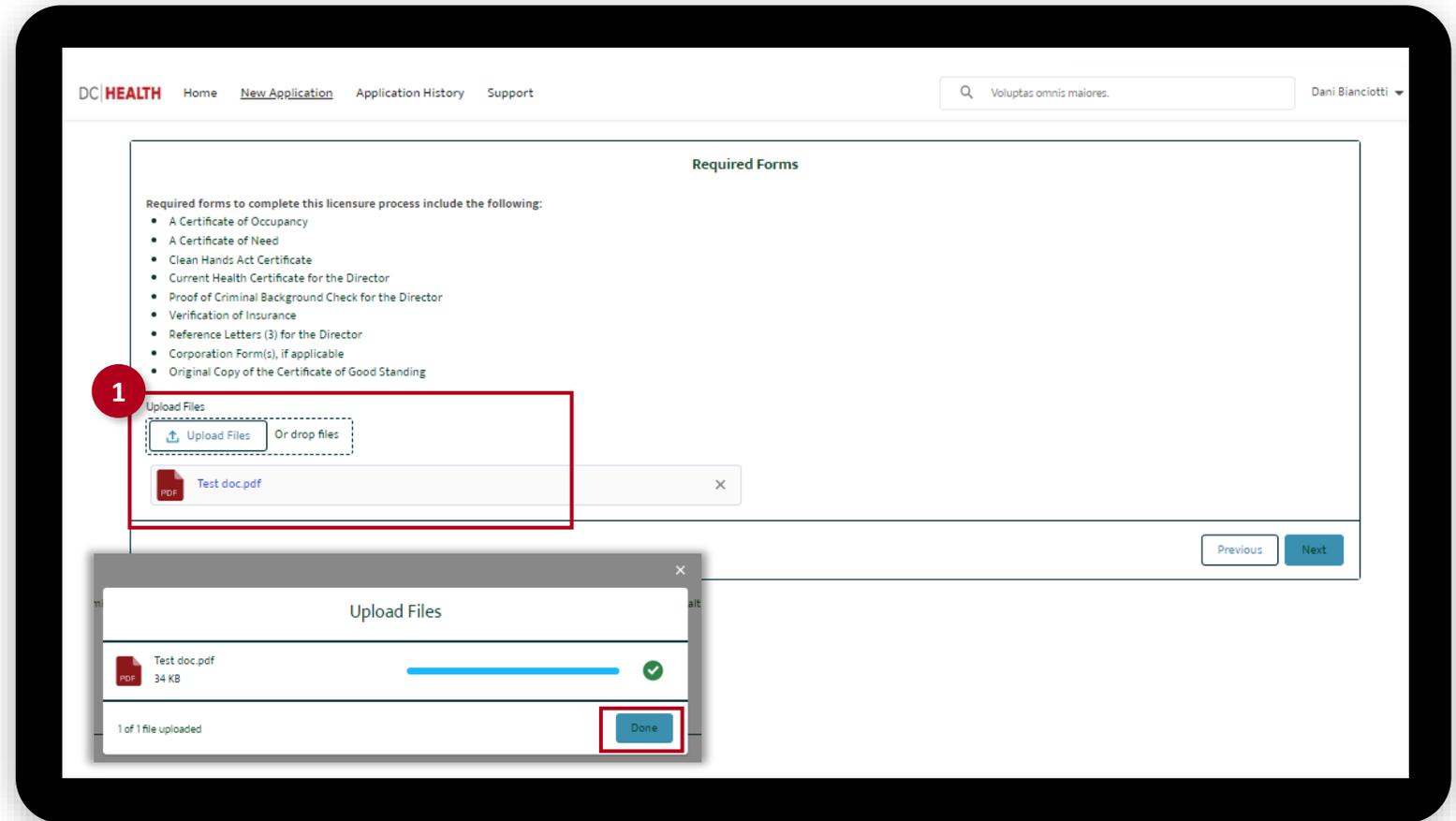
Submit

*The fields marked with * are mandatory and must be filled out to continue.*

Upload Required Forms

- 1 Upload the required forms:
 - Certificate of Occupancy
 - Certificate of Need
 - Clean Hands Act Certificate
 - Current Health Certificate for the Director
 - Proof of Criminal Background Check for the Director
 - Verification of Insurance
 - Reference letters for the director
 - Corporation Forms, if applicable
 - Original Copy of the Certificate of Good Standing

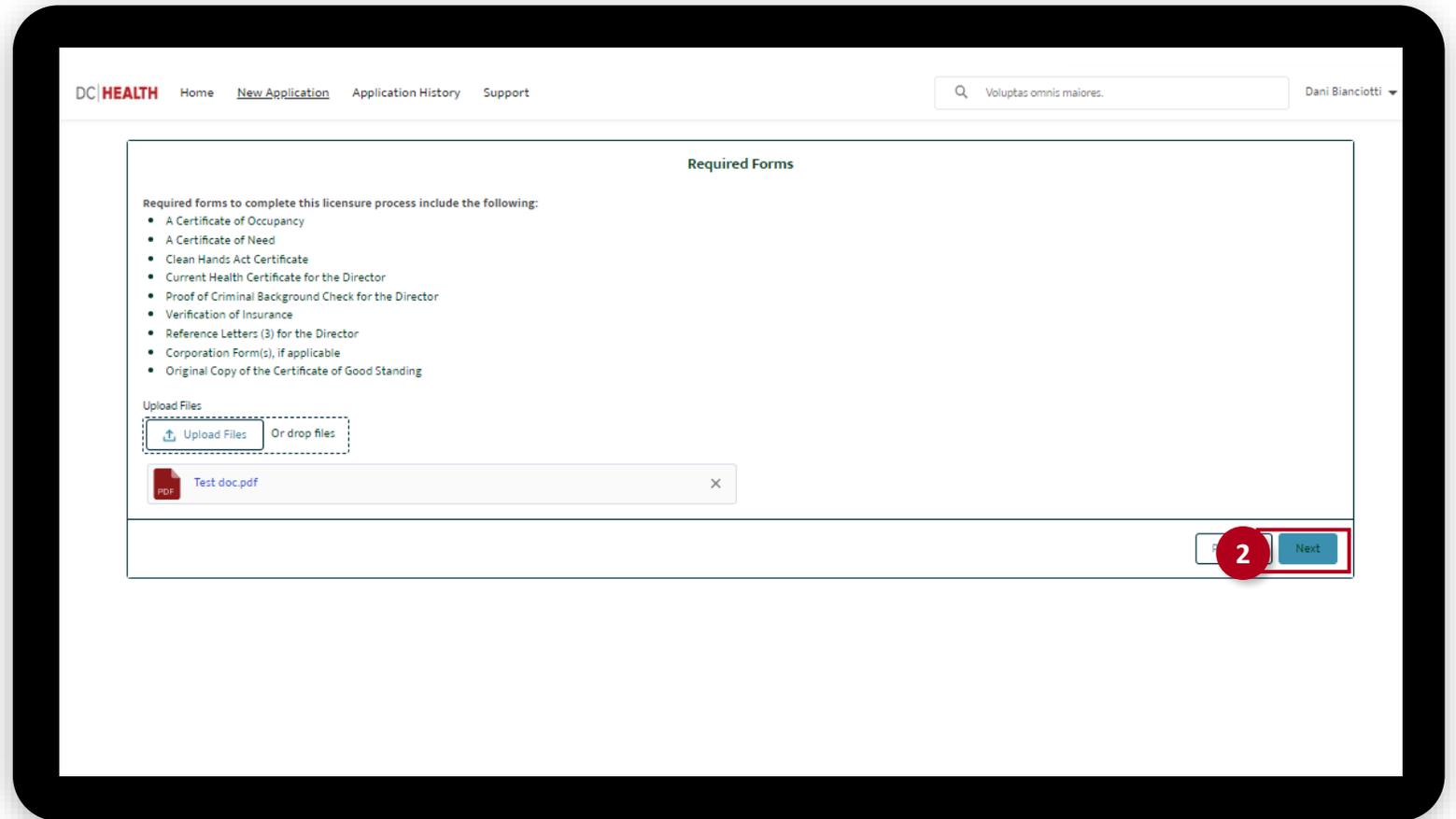
Once the document is selected and the checkmark appears, click the **Done** button in the pop-up.



The fields marked with * are mandatory and must be filled out to continue.

Upload Required Forms

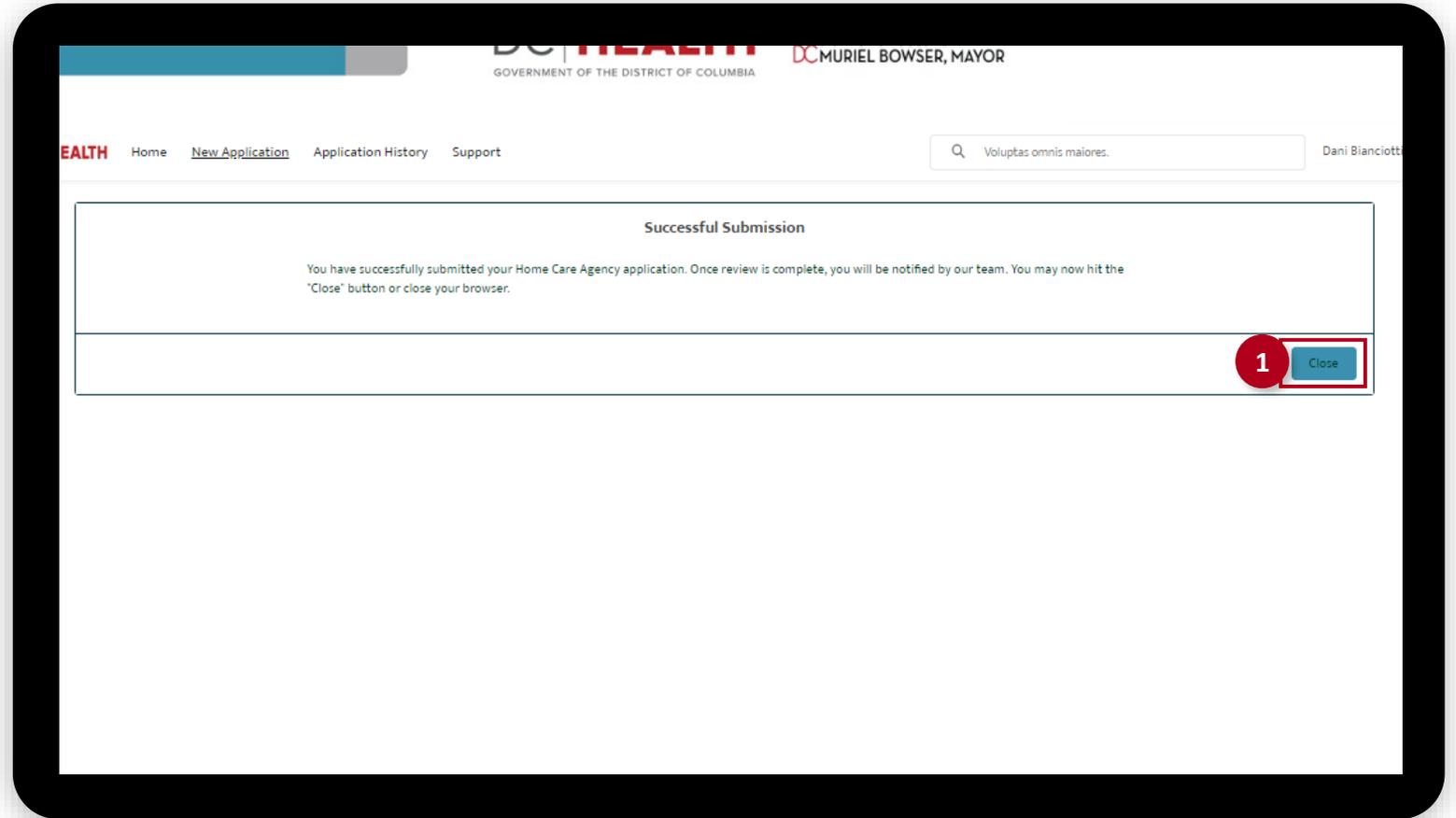
- 2 Once all the documentation is attached, click the **Next** button.



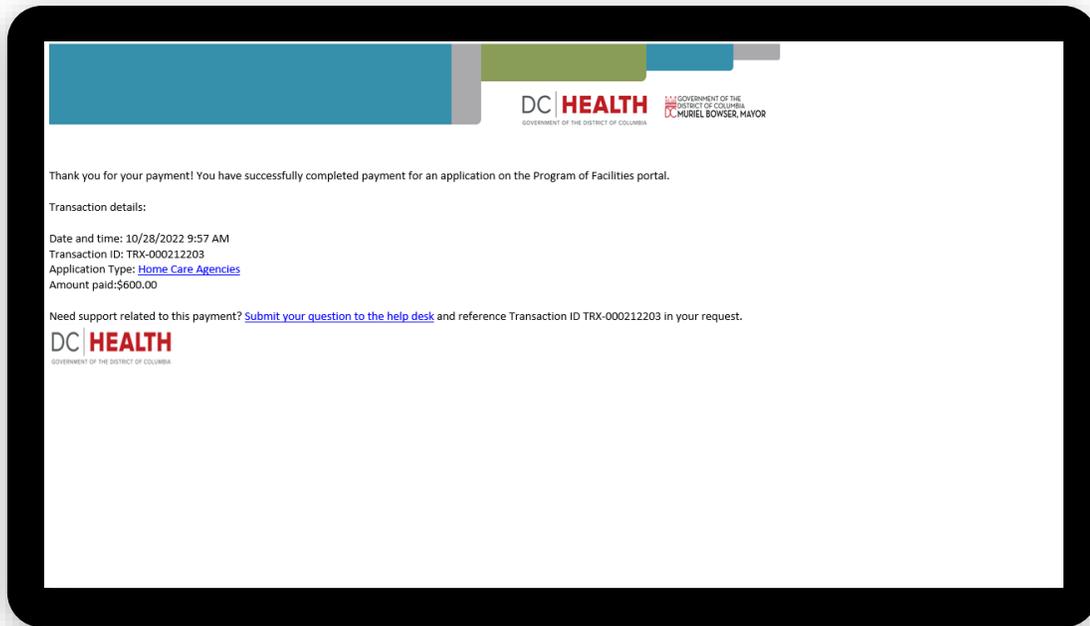
The fields marked with * are mandatory and must be filled out to continue.

Close the Application

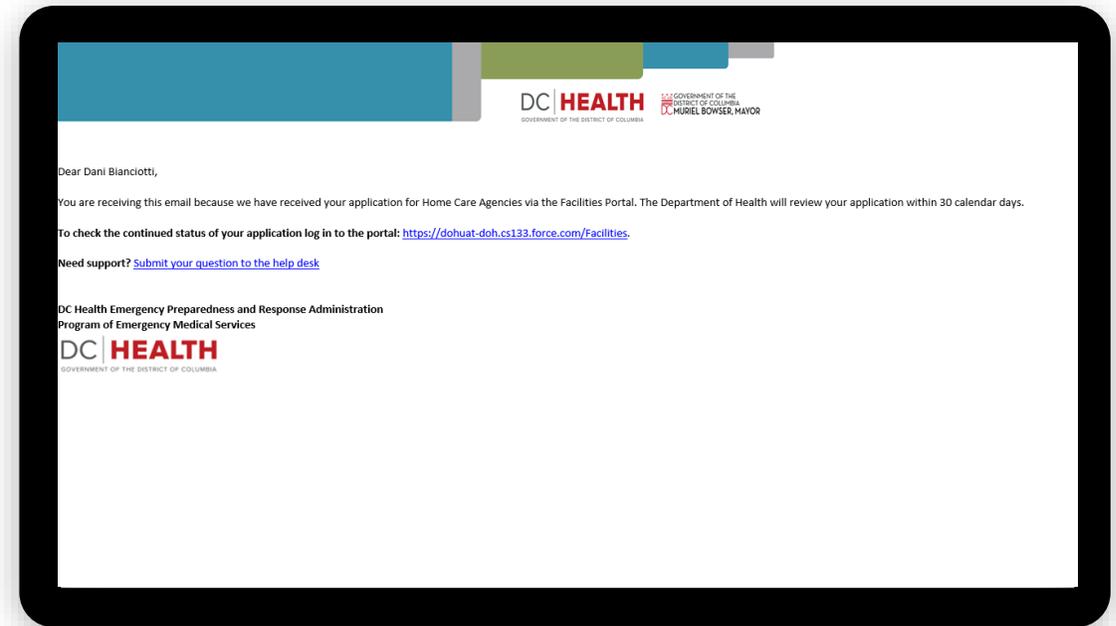
- 1 You have finished submitting your application. Click the **Close** button.



E-mail Confirmation



1 Check if you have received confirmation of payment.



2 Check if you have received confirmation for your application.

Thank you!